Disability Rights Connecticut
"Connecticut's protection and advocacy system"

846 Wethersfield Avenue
Hartford, CT 06114

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Comments in Opposition to OHS's
"Roadmap for Strengthening and Sustaining Primary Care"

Disability Rights CT is the state's designated Protection and Advocacy system for people with disabilities. DRCT advocates on behalf of individuals with a range of physical, mental health, intellectual and other developmental disabilities, and traumatic brain injury, on a variety of issues and in many different fora. One of our more recent priority areas is access to health care for people with disabilities, including particularly under the Medicaid program. People with disabilities have particular problems accessing health care, from difficulties in getting to medical appointments, challenges in communicating with providers, difficulties in physically accessing diagnostic equipment, the burdens of identifying the right providers to manage complex medical conditions which require regular monitoring, and, in some cases, an inability of providers to treat them with equal respect or to really listen to their concerns. As a long-time (31 year) advocate for Medicaid enrollees working in legal services programs in CT, I know that these problems are magnified for low-income people with disabilities, i.e., those on Medicaid.

We submit these comments in opposition to the entire Primary Care Roadmap in that it will significantly harm access to care for people with a range of disabilities, and will inevitably apply to the Medicaid program, if not *only* to the Medicaid program (as with OHS's past State Innovation Model (SIM) initiatives), where many of our clients must turn for their essential health care.

The Medicaid program is literally a life-saver for hundreds of thousands of enrollees in Connecticut, and particularly people with disabilities and individuals with complex medical problems. It also is a program that CT should be proud of: since jettisoning capitated insurers in January 2012 and moving to non-risk administrative services organizations (ASOs) and broad use of patient centered medical homes (PCMHs), the program has overall dramatically increased participation of providers, ended the shameful practice of insurers routinely denying prior authorization for care just to save money, and implemented real care coordination through PCMHs and Intensive Care Management run by the non-risk ASOs -- all the while saving hundreds of millions of dollars in avoided insurer company administrative costs and profits (leaving CT Medicaid with a very high "medical loss ratio" of 97%).

While there is much to appreciate about CT's Medicaid program, those of us who work in the trenches on behalf of Medicaid enrollees know that significant gaps remain. There

remain significant health disparities for Black and brown enrollees, people with disabilities and particularly Black and brown people with disabilities. Further, there are certain categories of services which are difficult to access for all enrollees largely because of too low reimbursement, including behavioral health services, adult dental and a range of specialists. The problem with specialists is particularly obvious because in general CT Medicaid pays only 57% of what Medicare pays for the same specialist services, contrasting sharply with CT Medicaid reimbursement for primary care which pays at a robust 95% of Medicare primary care rates. So, while there is no need to increase provider rates for primary care in Medicaid, which is already a success story, there certainly is in other areas of the program, and DRCT, like other advocacy groups, is advocating for correcting these remaining deficiencies.

But the Roadmap would put the emphasis in the entirely wrong place—throwing unneeded money at primary care while controlling overall costs, and thus forcing cuts in other parts of the Medicaid program, as well as making it difficult to address the **actual** problem areas by adopting higher payments for certain providers where payments really are too low.

The Roadmap is billed as a means to increase access to primary care, but it will do just the opposite because of the perverse incentives to deny office visits under the primary care capitation system. Providers will dramatically increase their capitated patient roles to mop up the regular capitated payments, increasing their revenue as the Roadmap intends, while denying office visits for which they no longer get paid and sending capitated patients out to specialists even when unnecessary or even inappropriate. The claim that capitation will allow "flexibility" for providers to provide innovative services not compensated under a fee for service fee schedule is no more true for capitation than under fee for service—in either case, extra services have to come out of the provider's pocket but, in the case of capitation, unlike fee for service, **all** services provided come out of the provider's pocket.

We are concerned with any system that sets payment per patient regardless of the amount of care that the patient uses. Such a system inherently encourages providers to underserve patients, especially those with complicated care needs. While individual providers may not **want** to act that way, most now work for corporate employers who will dictate how they practice. And the Roadmap just assumes that there will be measures of under-service which will magically identify "stinting" on care, when no such system has ever been devised, let alone adopted by a payer not interested in its detection. No effective system exists to assure that underservice, particularly for people with disabilities with complex medical problems for whom shunting off to specialists will be particularly easy to rationalize, does not occur.

We recognize that the Roadmap draft report asserts that its capitated payment model will apply to all payers, and therefore payers will not prefer patients in one plan over another. But we have seen this movie before and it is the highly controversial SIM initiative, referred to extensively in the report. There, as here, OHS (and its predecessor) insisted that its "payment reform" models, by which it meant shifting financial risk onto

providers, up to and including capitation, would apply to all payers and even agreed to start with commercial insurers before moving to Medicaid. But, because OHS simply could not control commercial payers, Medicare, and large self-funded employers, in the end all OHS had to show for the $42 million in taxpayer money spent over several years was a single program—the PCMH+ shared savings program **applied only to Medicaid.** (That program has been highly problematic, while apparently not accomplishing the number one goal it had: to save significant amounts of money for the state.) Since it is no different with the Roadmap, where other insurers will be beyond OHS's control, it is an entirely reliable prediction that only Medicaid providers will be enlisted into the new capitated payment scheme, and primary care providers, when it comes to scheduling Medicaid patients, will prefer instead those patients from commercial plans under which they will continue to get paid for seeing them.

Worse, the Roadmap will exacerbate access to care in **other** areas of the Medicaid program, like specialists and behavioral health, where access is already a problem in part due to low provider rates. This is because another goal of the Roadmap is to control costs overall and so it will force cuts in other parts of the program to pay for the unneeded increases in primary care expenditures. The last thing that people with disabilities on Medicaid, who already sometimes have difficulty accessing care, need is to for their primary care doctors to not want to see them because they would rather see a patient under another plan which is not participating in OHS's grand experiment in capitation, and instead prefer routinely to refer them out to specialists who are already difficult to schedule with and will become even harder to see because of the pressure to cut other rates.

Access to behavioral health services is of particular concern, especially as need has dramatically increased due to the pandemic -- and will continue post pandemic. We know that the mental health needs of CT residents will be significantly higher for many years to come. Reimbursement rates are already too low, as we have also seen with dramatic ill effect in the case of autism services for children. The Roadmap's insistence on increasing payments to primary care will necessarily add pressure to maintain insufficient behavioral health reimbursement rates which, in turn, will lead to a further contraction of services and only further compound the current mental health crisis. As just one example, regarding in-home services for children with autism, right now, even after the 4% CT Medicaid bump-up for autism providers in November, 2021, Massachusetts' Medicaid rates for board-certified behavioral analysts (BCBAs) are **52%** higher than CT Medicaid's rates ($122.50/hour in MA versus $80.66/hour under CT Medicaid).

All of this will be at the expense particularly of people with disabilities and Black and brown people, who disproportionately are benefitted by the Medicaid program. Any "reform" which **exacerbates** health disparities should be summarily rejected.

It is also important to address the myth that is driving the whole Roadmap: that there is a severe shortage of primary care providers and this is because they are underpaid, so we must address this by dramatically increasing their compensation so as to recruit more of them, while reducing expenditures for specialists, who are more expensive and overused.

While this may be true or somewhat true in some parts of the country, it is not true in CT and particularly not true for the CT Medicaid program, under which primary care providers are reasonably compensated and specialists are underpaid -- and access to primary care is not generally a problem, while access to specialists and behavioral health providers routinely is.

Finally, notwithstanding protestations to the contrary in the Roadmap, only a small slice of stakeholders had any meaningful input into the Roadmap. The three OHS "Consumer Advocate" advisory groups identified in the report had members entirely picked by OHS. The entire process leading up to the Roadmap lacked transparency and had the clear design to reach OHS's pre-ordained plan. The only meaningful outside input was provided by associations of primary care providers who are the sole beneficiaries of the plan, because it will significantly increase their own remuneration. This has led to a draft plan that does not serve anyone but primary care providers and, even for primary care, will incentivize these providers to deny medical appointments because payments for actual office visits (or telehealth visits) will come to an end.

We urge OHS to reject the current Roadmap plan and work toward real improvements in health care delivery that have far greater input and support from a full range of consumers, independent advocates and provider groups, such as buttressing the effective non-financial risk PCMH program and increasing payment rates for behavioral health, dental services and specialists under Medicaid. This is something independent advocates are happy to help with.

Thank you for your consideration of these comments.

Sheldon Toubman
Litigation Attorney
Disability Rights CT
sheldon.toubman@disrightsct.org
(475)345-3169